Greater Washington
Maternal
Fetal Medicine
& Genetics

WAIVER OF BENEFITS FOR LAB TESTS

I, ____ understand that I am receiving
(Patient or responsible party)

Medical services/Lab test from Greater Washington Maternal-Fetal Medicine and Genetics without confirmation that My Insurance Company may pay my claims at a lower level of benefits, or deny benefits entirely. In the event that benefits are denied entirely, I agree to be financially responsible for full payment of services rendered to me; In the event that my claims are paid at a lower level of benefits, I agree to be financially responsible for that portion of the allowed amount which is not paid by My Insurance Company.

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(Patient or responsible party) (Date)